DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 12/22/12

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445154	A. BUILDING _____ B. WING _____	11/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUALITY CARE HEALTH CENTER	932 BADDOUR PARKWAY LEBANON, TN 37087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 159 SS=C	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the	F 159	F159 Personal Funds 1. Effective November 8, 2012, the administrator established a resident personal fund and a Weekend Trust Fund Access policy (see attached) that will make personal funds available to all residents on weekends from 8:00AM to 4:00PM from the Business Office. 2. On November 7, 2012 the administrator notified all residents and resident's POA by letter about the accessibility to their personal funds on the weekend. A copy of this letter (see attached) was posted in the Business Office window on November 8, 2012. 3. All Business office staff were in-serviced on this access on Nov. 8, 2012 Any staff not attending in-services on these dates will not be allowed to work until they have attended the in-services	11/8/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 159	Continued From page 1 resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on resident and facility staff interviews and review of the Trust Fund Trial Balance accounts, the facility failed to provide weekend access to personal funds managed by the facility for eligible residents. The findings included: Interview with resident #72 on November 5, 2012, at 3:10 p.m., and resident #152 on November 6, 2012, at 10:00 a.m. confirmed the residents were not able to access personal funds at the facility on the weekends. Review of the facility's Trust Fund Trial Balance revealed ninety-four residents with personal fund accounts managed by the facility. Interview with the Administrative Assistant, in the business office on November 7, 2012, at 8:50 a.m., confirmed the facility does not routinely provide access to personal funds for the residents on weekends.	F 159	4. Beginning November 10, 2012, weekend access will be monitored weekly by the Business Office Manager and reported monthly to the Administrator. The Administrator will provide a written quarterly report to the QA/PI Committee beginning at the next quarterly meetings for 3 quarterly meetings. The next quarterly QAPI Committee meeting is scheduled for December 13, 2012. The Chairman of the QA/PI Committee will brief the Governing Body at their quarterly meetings following the QAPI meeting. Attachments: 1) Policy for Weekend Trust Fund 2) Copy of Letter posted on Window	
		F272	F272 COMPREHENSIVE ASSESSMENT 1. Upon being notified by the survey team on November 7, 2012 that resident #273 had not been properly assessed for a needed assistive device, resident #273 was assessed by the Physical Therapy Director 11/7/12 for an assistive device to improve and maintain functional abilities The result of that assessment was an	11/21/12

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F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	assistive device more appropriate to the resident. 2. On November 8, 9,& 12, 2012 all residents utilizing assistive devices were assessed by the MDS Coordinator and physical therapy to ensure appropriateness of their assistive device. All residents were found to have appropriate assistive device (see attached assessment list). 3. Beginning November 21, 2012 residents with new orders for assistive devices will be assessed and evaluated within 72 hours for appropriateness by the therapy staff and recorded in their progress notes. This will be monitored weekly by MDS Coordinator for a period of 6 months or longer until 100% compliance is achieved. (see attached monitoring tool) 4. Beginning November 21, 2012, the MDS coordinator will report the outcomes of the monitoring of the timeliness and appropriateness of the assistive devices to the quarterly QAPI committee beginning December 13, 2012 and continue for the next 2 quarters. The Chairman of the QA/PI Committee will report to the Governing Body following the quarterly QAPI meeting.	

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F 272	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to assess the needs of one resident (#273) for assistive devices to improve/maintain functional abilities of forty-four residents reviewed. The findings included: Resident #273 was admitted to the facility on June 13, 2012, with diagnoses including Morbid Obesity, Urinary Incontinence, Schizophrenia, Mental Retardation, and Encephalopathy. Medical record review of the quarterly Minimum Data Set (MDS) dated September 7, 2012, revealed the resident was unable to answer any of the questions on the Brief Interview for Mental Status (BIMS) with a score of 0 with the highest possible score being 15. Continued review of the September quarterly MDS revealed the resident required extensive assistance of two persons for bed mobility, and was dependent on two persons for transfers. Medical record review of the Occupational Therapy Treatment Encounter Note dated July 13, 2012, revealed Self Care Management instruction had been provided in toileting/clothing management techniques by the therapy department to the resident and facility staff. Medical record review of the interdisciplinary team note revealed the resident's weight for September 12, 2012, was 383 pounds.	F 272	Attachments: 3) List of Residents assessed by MDS Coordinator and Therapy staff for appropriate assistive device. 4) Monitoring tool for reporting to QAPI committee on the timeliness and evaluation of assistive device.	

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F 272	Continued From page 4 Observation on November 7, 2012, at 9:15 a.m., revealed Certified Nurse Technician (CNT) #1, transferred resident #273 to the bedside commode. Continued observation revealed the resident's feet did not touch the floor, and the resident's legs were dangling. Continued observation revealed CNT #1 instructed resident #273 to move back on the toilet seat to keep the resident off the edge. Continued observation revealed the resident used the rail/armrest on the side of the bedside commode to reposition self. Observation and interview with the Unit Manager, Licensed Practical Nurse #1, on November 7, 2012, at 9:20 a.m., in the resident's room, confirmed the resident's legs were dangling, and the feet should be touching the floor. Interview with the Rehabilitation Director on November 7, 2012, at 9:44 a.m., at the nurse's station confirmed the resident had not been assessed for the appropriate height of the bedside commode chair that would allow the resident's feet to touch the floor.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279	F279 DEVELOP COMPREHENSIVE CARE PLANS 1. On November 8, 2012, upon becoming aware of no care plan for resident # 22 concerning vision difficulties, the MDS Coordinator revised the comprehensive plan of care to address vision difficulties. 2. Beginning November 10 and continuing through November 21, 2012 all CAAS were reviewed by the	11/24/12

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F 279	Continued From page 5 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to develop a comprehensive plan of care for vision for one resident (#228) of fourty-four residents reviewed. The findings included: Resident #228 was admitted to the facility on May 26, 2010, with diagnoses including Convulsions, Dementia, Senile Depression, Dysphagia, Acute Conjunctivitis, Edema, Generalized Anxiety and Generalized Pain. Medical record review of the annual Minimum Data Set (MDS) dated May 16, 2012, revealed vision was marked as impaired. Further review revealed the resident was able to see large print, but not regular print in newspapers/books. Medical record review of the care plan created May 16, 2012, and updated August 15, 2012, revealed no problem/need entered for vision. Interview with MDS Coordinator #1, on November	F 279	MDS nursing staff to ensure all triggered and/or identified areas listed on the MDS assessment were care planned. 3. On November 13, 2012 the DON conducted an in-service with MDS staff (RNs & LPNs) concerning triggered problems on the CAAS must be care planned individually and the MDS staff must compare the CAAS to the comprehensive plan of care to ensure no problems are missed. Beginning November 24, 2012, the DON and or ADON will monitor all CAAs and Care Plans completed during a 6 weeks period to ensure no identified problems are missed. DON and/or ADON will continue monitoring 10% on a monthly basis for 3 months until substantial compliance has been achieved. 4. DON will report outcomes of the Care Plan to the QAPI committee quarterly for two quarters. The next quarterly QAPI Committee meeting is scheduled for December 13, 2012. The Chairman of the QA/PI Committee will report to the Governing Body following the quarterly QAPI meeting.	

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F 279	Continued From page 6 7, 2012, at 10:10 a.m., in the MDS office confirmed vision was listed on the annual MDS as a problem, but was not carried over to the care plan. Further interview revealed a notation had been made on the CAT worksheet "will proceed with c/p (care plan)", but the facility had failed to develop a plan of care for vision.	F 279	Attachments: 5) Monitoring spreadsheet for reporting to QAPI committee on Care plans for identified problems on the MDS assessments.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to ensure appropriate measures to prevent skin breakdown related to the application of arm sleeves, as indicated on the care plan, for one resident (#266) of three residents reviewed for pressure ulcers from forty-four residents reviewed. The findings included: Resident #266 was admitted to the facility on April 1, 2012, with diagnoses including Pulmonary Embolism, Cerebral Vascular Accident, Muscle Weakness, Hypertension, Senile Depressive Disorder with Psychosis, and Esophageal Reflux. Medical record review of the quarterly Minimum Data Set (MDS) dated September 25, 2012, revealed the resident had severe cognitive impairment, and required extensive assistance	F 282	F282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 1. On November 7, 2012, upon being notified by survey team that the facility failed to ensure appropriate measures were followed for resident # 266 as indicated on the care plan concerning arm sleeves, the MDS Coordinator reviewed the comprehensive plan of care and placed the Posey sleeves on the resident immediately. 2. Beginning on November 10and continuing through November 21, 2012, the DON, ADON and Wound Care Staff reviewed all residents with wound care plans to determine if appropriate measures were in place to prevent skin breakdowns. All residents were found to have appropriate care plans. 3. Beginning 11/7/12 and continuing through 11/21/12, the DON and/or	11/21/12

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F 282	Continued From page 7 with Activities of Daily Living. Medical record review of the Care Plan, dated October 18, 2012, revealed "...at risk for skin breakdown related to present skin impairment...h/o (history of) resolved/healed pressure ulcers...arm sleeves to bilateral arms at all times except bathing..." Observation on November 6, 2012, at 4:25 p.m., in the resident's room, revealed the resident lying on the bed with no arm sleeves in place. Observation on November 7, 2012, at 7:40 a.m., in the resident's room, revealed the resident lying on the bed with no arm sleeves in place. Observation and interview on November 7, 2012, at 7:45 a.m., with Licensed Practical Nurse (LPN) #1, in the resident's room, confirmed the arm sleeves were not in place and the care plan was not followed.	F 282	ADON performed in-services with all staff (RNs, LPN, & CNTs) concerning following interventions put in the care plan i.e. arm sleeves to prevent skin breakdown. Any staff not attending in-services on these dates will not be allowed to work until they have attended the in-services. The Wound Care staff will monitor weekly all residents who have interventions such as arm sleeves, padded w/c arms, or any special treatment to prevent skin breakdown and provide a list of residents monitored each week to DON and/or ADON and record any variances noted each week	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure the safe	F 323	4. The DON will provide the outcomes of the monitoring to the QA/PI Committee for the next two quarters. The next quarterly QAPI Committee meeting is scheduled for December 13, 2012. The Chairman of the QA/PI Committee will report to the Governing Body following the quarterly QAPI meeting. Attachment: 6) Monitoring tool to be used to record weekly reviews of interventions on care plan is carried out	

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F 323	Continued From page 8 use of an assistive device in regard to chair heigth for one resident (#273) of forty-four residents reviewed. The findings included: Resident #273 was admitted to the facility on June 13, 2012, with diagnoses including Morbid Obesity, Urinary Incontinence, Schizophrenia, Mental Retardation, and Encephalopathy. Medical record review of the quarterly Minimum Data Set (MDS) dated September 7, 2012, revealed the resident was unable to answer any of the questions on the Brief Interview for Mental Status (BIMS) scoring 0 with 15 being the highest possible score. Continued review of the quarterly MDS revealed the resident required extensive assistance of two persons for bed mobility, and was dependent on two persons for transfers. Medical record review of the Occupational Therapy Treatment Encounter Note dated July 13, 2012, revealed Self Care Management Instruction had been provided in toileting/clothing management techniques to the resident and facility staff. Medical record review of the interdisciplinary team note revealed the resident's weight on September 12, 2012, was 383 pounds. Observation on November 7, 2012, at 9:15 a.m., revealed Certified Nurse Technician (CNT) #1, transferred resident #273 to the bedside commode. Continued observation revealed the resident's feet did not touch the floor, and the resident's legs were dangling approximately six	F 323	F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVISES 1. On November 7, 2012, upon being notified by survey team that the facility failed to ensure the safe use of an assistive device for resident # 273, the Unit manager brought a bedside commode with the appropriate height that allowed resident's feet to touch the floor. 2. On November 8, 9 and 12, 2012 the MDS Coordinator and Director of Therapy assessed all utilizing a bedside commode for appropriate and safe use 3. Beginning on November 21, 2012 to November 26, 2012, in-services were conducted by the DON /ADON &/Therapy Director for all staff (RNs, LPNs, CNTs, & Rehab) proper and safe assistive seating for residents. Any staff not attending In-services on these dates will not be allowed to	11/26/12

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		F323	F323	

work until they have attended the in-services.
Beginning November 21, 2012, all new residents admitted who have orders for assistive devices (Bedside Commode) will be assessed by Therapy staff to determine suitability according to resident's physical capabilities/limitations. This assessment will be recorded in their progress notes. Beginning December 1, 2012, the MDS Coordinator will monitor monthly the assessments and documentation completed by Therapy staff and report the outcomes to the QAPI Committee.
4. The MDS Coordinator will report monitoring outcomes to the QA/PI Committee at the next two quarterly meetings. The next quarterly QAPI Committee meeting is scheduled for December 13, 2012. The Chairman of the QA/PI Committee will report to the Governing Body following the quarterly QAPI.

Attachment:
4) Monitoring tool for reporting to QAPI committee on the timeliness and evaluation of assistive device.

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F 323	Continued From page 9 inches from the floor. Continued observation revealed CNT #1 instructed resident #273 to move back on the toilet seat to keep the resident off the edge. Continued observation revealed the resident used the rail/armrest on the side of the bedside commode to reposition self. Observation and interview with the Unit Manager, Licensed Practical Nurse #1, on November 7, 2012, at 9:20 a.m., confirmed the resident's legs should not dangle and the feet should touch the floor. Interview with the Rehabilitation Director on November 7, 2012, at 9:44 a.m., at the nurse's station confirmed the resident's feet should touch the floor when properly seated on the bedside commode.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility dietary departments, Cedars and Quality, failed to maintain equipment in a sanitary manner.	F 371	F371 FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY 1. On Nov. 7, 2012, upon being notified of black debris hanging from the ceiling of the walk-in refrigerator, in front of the condenser unit in the Cedars Dietary Department; and debris present on the floor of the walk-in freezer floor of the Quality Dietary Department, the Dietary staff immediately cleaned the debris. 2. The facility Dietitian and the Dietary staff manager inspected all of the Dietary areas for debris, and found none present. On Nov 5, the RD and Dietary Manager in-serviced	12/10/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445154	A. BUILDING _____ B. WING _____	11/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUALITY CARE HEALTH CENTER	932 BADDOUR PARKWAY LEBANON, TN 37087

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F 371	Continued From page 10 The findings included: Observation on November 5, 2012, beginning at 9:35 a.m., with the facility Registered Dietitian (RD) present, revealed the following: Cedars dietary department beginning at 9:35 a.m.: 1.) The walk-in refrigerator had black debris hanging from the ceiling, in front of the condenser unit, with open cases of tomatoes, cucumbers, and fresh eggs stored in the refrigeration unit. 2.) The walk-in refrigerator had ice build-up on the exterior of the condenser unit. 3.) The back side of the interior lid of the tilt skillet had a build-up of greasy debris. Quality dietary department beginning at 10:36 a.m., with the RD and Certified Dietary Manger (CDM) present: 1.) The walk-in freezer had a storage rack on the left side with a rusted surface on the support pole closest to the door. 2.) The walk-in freezer floor by the door jamb had an accumulation of debris present. 3.) The walk-in freezer and the walk-in refrigerator had a build-up of ice on the exterior of the condenser units. 4.) The can opener on the cook side had a build-up of black sticky debris in the blade slot area. 5.) The exterior top of the convection oven had an accumulation of dust present. 6.) The range top back splash had a build-up of dark colored debris present. 7.) The exterior surface and the back side of the interior lid of the tilt skillet had a build-up of greasy debris.	F 371	all the dietary staff of Cedars and Quality Dietary Departments concerning proper cleaning of ceiling vents, floors and floor space. Also included in the in-services was the use of a weekly sanitation checklist by Dietary managers. Any staff not attending in-services on these dates will not be allowed to work until they have attended the in-services 3. For the next 12 weeks beginning Nov. 13, 2012, and then monthly for the next four months, the Dietary Manager will inspect the facility dietary refrigerators on a daily basis for debris and record the inspection as a part of their temperature log. The Dietary Manager will provide those logs as well as the weekly sanitation checklist to the Registered Dietitian on a weekly basis for the next 12 weeks, then monthly for the next four months. 4. The Registered Dietitian will report the monitoring outcomes of the daily inspections and completion of the sanitation checklist to the QA/PI at the next 2 quarterly meetings. The next quarterly QAPI Committee meeting is scheduled December 13, 2012. The Chairman	

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F 371	Continued From page 11 Interview on November 5, 2012, at the times of the observations, in the respective dietary departments, with the RD and/or CDM present during the observations, confirmed the following: Cedars dietary department beginning at 9:35 a.m.: The walk-in refrigerator had black debris hanging from the ceiling, in front of the condenser unit, with exposed raw vegetables and fresh eggs stored in the unit. The walk-in refrigerator had a build-up of ice on the exterior of the condenser unit. The back side of the interior lid of the tilt skillet had a build-up of greasy debris. Quality dietary department beginning at 10:36 a.m.: The walk-in freezer storage rack, on the left side, had a rusted surface on the support pole and the floor jamb area had an accumulation of debris present. The walk-in freezer and the walk-in refrigerator exterior of the condenser units had a build-up of ice. The cook side can opener had a build-up of black sticky debris. The exterior top surface of the convection oven had an accumulation of dust. The range top back splash had a build-up of dark colored debris present. The exterior surface and the back side of the interior lid of the tilt skillet had a build-up of greasy debris.	F 371	of the QA/PI Committee will report to the Governing Body following the quarterly QAPI meeting. Attachment: 7) Temperature Log 8) Weekly Sanitation Checklist 1. Upon being notified of the ice build-up on the exterior of the condenser unit of the walk-in refrigerator in the Cedars Dietary Department; and ice buildup on the condenser unit of both the walk-in refrigerator and walk-in freezer of the Quality Dietary Department, the facility Maintenance Director contacted a refrigerator repairman to have the refrigeration units inspected, serviced and/ or repaired by 12/10/12. (See Purchase Order) While the refrigeration units are being inspected, services and/or repaired to eliminate icing, food items currently stored in the refrigeration units will be stored in refrigeration trailers. (see Purchase Order). This is scheduled to be completed on 12/10/12 2. The remaining refrigeration unit in Cedars Dietary was inspected for	

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		F371	F371	

ice buildup and no buildup was found.
3.Begining on 12/10/12, and for the next 12 weeks, and then monthly for the next four months, the Dietary Manager will inspect the facility refrigerators on a daily basis for ice build-up and record the inspection as a part of their temperature log. The Dietary Manager will provide those logs to the Registered Dietitian on a weekly basis for the next 12 weeks, then monthly for the next four months.
4. The Registered Dietitian will report monitoring outcomes concerning the inspections of the refrigerator temperatures and ice buildup to the QA/ at the next two quarterly meetings. The next quarterly QAPI Committee meeting is scheduled for December 13, 2012. The Chairman of the QA/PI Committee will report to the Governing Body following the quarterly QAPI meeting.

Attachment:
9) Purchas order refrigerator repair
10) Purchase order trailer rental
7) Temperature Log/Inspection log for inspection of ice buildup.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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		F371	F371 1. On November 5, 2012, upon being notified of debris on the tilt skillet in the Cedars Dietary Department; and the debris on the can opener, convection oven, range top back splash, and tilt skillet in the Quality Dietary Department, the dietary staff immediately cleaned the equipment. 2. The remaining food preparation equipment in both the Cedars and Quality Dietary Department were checked that day for cleanliness and found to be free of debris. On 11/5/12, Dietary employees for Cedars and Quality Dietary Department were in-serviced on proper cleaning of food preparation equipment. Any staff not attending in-services on these dates will not be allowed to work until they have attended the in-services	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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		F371	F371 3. Dietary manager will monitor the daily cleaning of food preparation equipment on a daily basis and record those checks on a weekly sanitation checklist to be provided to the facility RD. 4. The RD will report the monitoring outcomes concerning the proper cleaning of food preparation equipment to the QA/PI Committee at the next 2 quarterly meetings. The next quarterly QAPI Committee meeting is scheduled for December 13, 2012. The Chairman of the QA/PI Committee will report to the Governing Body following the quarterly QAPI meeting. Attachments: 8) Weekly sanitation checklist	
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION	F 456	F456 ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITIONS 1. On 11/8/12 the facility maintenance manager ordered a replacement door (see attached Purchase Order) for the Quality Dietary walk-in refrigerator. The door is projected to be delivered on 11/29/12. While the food items stored in the refrigeration units of	12/10/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445154	A. BUILDING _____ B. WING _____	11/07/2012

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F 456	Continued From page 12 The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility dietary department failed to maintain the walk-in refrigerator floor surface; and failed to maintain the walk-in refrigerator door gasket in one of four walk-in units. The findings included: Observation of the Quality dietary department on November 5, 2012, beginning at 10:36 a.m., with the Registered Dietitian (RD) and Certified Dietary Manager (CDM) present, revealed the entire walk-in refrigerator floor surface was rusted. Further observation revealed the walk-in refrigerator door gasket was coming off near the handle. Interview with the RD and the CDM, on November 5, 2012, beginning at 10:36 a.m., in the Quality dietary department, confirmed the entire floor surface of the walk-in refrigerator was rusted and the door gasket was coming off near the handle of the door.	F 456	the Cedars and Quality Dietary Department are stored in the refrigerated trailers from 12/3/12 till 12/10/12, the facility maintenance department will install the new door and replace the floor on the Quality Dietary Departments refrigerator. 2. The remaining refrigeration equipment of both Cedars and Quality Dietary Departments were checked by facility maintenance personnel and found to be serviceable. 3. The Dietary Manager will inspect all refrigeration equipment weekly for needed service and report the results of that inspection monthly to the RD. 4. The RD will report to the QA/PI Committee on the results of this inspection at the next 2 quarterly meetings. The next quarterly QAPI Committee meeting is scheduled for December 13, 2012. The Chairman of the QA/PI Committee will report to the Governing Body following the quarterly QAPI meeting. Attachment: 11) Purchase Order for refrigerator door	